XHANCE®
(fluticasone propionate) nasal spray 93 mcg

Preferred Pharmacy Network Form

Please fill out the Patient Information, Patient Insurance, and Preferred Pharmacy sections and take this form to your doctor.

Patient Information

Patient Name _____ DOB ____/____/_____ Sex ☐ M ☐ F

Street Address _____ City _____ State _____ ZIP_____

Mobile Phone (_____) _____-_____ Home Phone (_____) _____-_____ Email _____

Patient Insurance Information

Prescription Plan Name _____ Group # _____

Policy # _____ Rx BIN # _____ Rx PCN # _____

Insurance Phone (_____) _____-_____ Policy #_____ Policyholder Name _____ DOB _____/_____/_____

Preferred Pharmacy Information (Please use the pharmacy locator at xhance.com/pharmacylocator.)

Pharmacy Name _____ Fax (_____) _____-_____ Phone (_____) _____-_____

The following section is to be filled out by your doctor's office

Prescriber Information

Prescriber Name _____ ☐ Allergist ☐ ENT ☐ Other _____ NPI # _____ Tax ID # _____

Facility Name/Address _____ City _____ State _____ ZIP _____

Office Contact Name _____ Office Contact Email _____

Phone (_____) _____-_____ Fax (_____) _____-_____

Clinical Information for Insurance Prior Authorizations (Please include a copy of patient's clinical notes, if available.)

Diagnosis

☐ J33.0 Polyp of nasal cavity ☐ J33.1 Polypoid sinus degeneration ☐ J33.8 Other polyp of sinus ☐ J33.9 Nasal polyp, unspecified

☐ Other Dx code(s) _____

Most Recent Steroid Treatment

☐ Flonase ☐ Dymista ☐ QNASL ☐ Nasonex ☐ Nasacort ☐ Rhinocort ☐ Other _____

Approximate start and end dates of most recent treatment _____

Surgical history _____

Drug allergies _____

Prescription

Rx: XHANCE (fluticasone propionate) nasal spray 93 mcg, NDC: 71143-375-01

☐ 1 spray per nostril twice daily: Dispense 1 unit
☐ 2 sprays per nostril twice daily: Dispense 2 units

REFILLS: 1 2 3 4 5 6 12

Prescriber Authorization (Required)

I authorize the designated pharmacy to act as an agent to initiate and execute the insurance prior authorization process, if necessary, for this prescription and any future fills of the same prescription for the patient listed above. I understand that I can revoke this designation at any time by providing written notice. The patient listed above has agreed to enroll in the XHANCE Copay Program.

Prescriber's Signature _____/_____ Date ____/____/_____

(Substitutions Permitted) (Dispense as Written)

PLEASE COMPLETE AND SIGN THIS FORM. FAX COMPLETED FORM TO PREFERRED PHARMACY ABOVE.

Offer not valid for patients enrolled in Medicare, Medicaid, or other federal or state healthcare programs.
State restrictions may apply or be prohibited by law. Program may limit the number of patients that can be enrolled.